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THE BRITISH JOURNAL OF DERMATOLOGY

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THE BRITISH
JOURNAL OF DERMATOLOGY.
AUGUST, 1911.

A CASE OF SPOROTRICHOSIS.

By H. G. ADAMSON, M.D., F.R.C.P.

The affection called sporotrichosis, now so well known in America and in France, has not been met with in this country until quite recently. At the meeting of the Dermatological Section of the Royal Society of Medicine on May 18th, 1911, I showed a case of sporotrichosis in an Englishman who had recently come from Brazil. This was the first case to be exhibited in this country, and a brief note was published in the *British Journal of Dermatology* for June, 1911. In the *British Medical Journal* of July 1st, 1911, Dr. Norman Walker published an undoubted example of sporotrichosis in which the infection had taken place in Cumberland. With the exception of a doubtful case published by Dr. v. Ofenheim in the *Lancet* of March 11th, 1911, these two cases are the only examples that have yet been recorded in Great Britain. Since my own case occurred in a patient infected in Brazil it loses the interest it would have as an English case; but it is instructive to come face to face with a disease which one has hitherto only read about, and it was for this reason that I exhibited the patient at the meeting of the Dermatological Section, and that I now publish my notes and photographs relating to the case.

I shall here make no attempt to review the now very extensive literature of sporotrichosis. The exhaustive monographs of De Beurmann and Gougerot and of Bloch should be read by those interested in the subject, and also a recent summary of the knowledge of sporotrichosis by the late Dr. Hyde.

The main facts are as follows:

The first case of sporotrichosis was reported in America by Schenk

in 1898 as "refractory subcutaneous abscesses caused by a fungus probably related to sporotrichia." Hektoen and Perkins, also in America, published a similar case in 1900, and obtained a fungus, which they named Sporothrix Schenkii. Attention was not again drawn to this disease until 1906, when De Beurmann and Gougerot published an important paper in the *Annales de Dermatologie* and reported five examples of sporotrichosis. From this time the study of sporotrichosis has been taken up with vigour both in France and in America, and many cases have been published, and much histological, bacteriological and experimental work has been done by many observers.

In the early American cases the infection took place in the index finger and was followed by a train of subcutaneous abscesses, connected by a chain of lymphangitis, along the arm. It was the refractory nature of these lesions to surgical treatment which led Schenk to examine them culturally and thus to discover the sporothrix.

In the French cases the lesions have been mainly multiple and widely spread abscesses, generally hypodermic, but sometimes also dermic and epidermic. Some of the lesions were like gummata and broke down and ulcerated; others simulated Lupus verrucosus.

Further study of the disease has shown that it is not always confined to the skin. The lymphatic glands may become involved. Intra-muscular abscesses, abscesses in bone, ulcerations in the mucous membranes of the throat, lesions in the conjunctivæ, iritis simulating syphilitic iritis, gummatous lesions in the testicle, and joint affections have also been reported.

Histologically the lesions show sometimes the characters of tuberculosis, sometimes those of syphilis.

De Beurmann and Gougerot describe the lesions as presenting three types of cell infiltration in combination: (*a*) A lympho-connective tissue of syphiloid type; (*b*) an epithelioid (with giant-cells) or tuberculoid type; (*c*) a polynuclear or ecthymatiform type.

De Beurmann states that the parasites have not with certainty been demonstrated in sections except in the experimental lesions in the rat. In human lesions certain globular forms have been seen, but it has been impossible to differentiate these clearly from degenerated nuclei. In the rat the micro-organism occurs in the

tissues in the form of short or ovoid elements (forme *globuleuse*) included in the cells, notably in giant-cells. These De Beurmann regards as special forms and not as spores, which Hektoen believed them to be.

In smears from abscesses the fungus is only rarely and with difficulty demonstrated, as short or oblong rods, 2–5 μ × 1–3 μ, free or in phagocytes.

The only certain method of demonstrating the fungus is by cultures, which are readily obtained on most of the usual media.

On Sabouraud's peptone-glucose-agar at room temperature, small whitish acuminate colonies with a fine-rayed margin appear on the fourth to the sixth day. They slowly increase in size, and become dark brown in colour and convoluted. Films from the cultures show long filaments, 2 μ broad, together with numerous ovoid spores 5–6 μ × 3–4 μ attached to the filament by a short pedicle either singly or in groups of three to thirty.

As to the source of infection, it has been suggested that this may take place from contact with or ingestion of unclean vegetables. De Beurmann has found the sporothrix on decaying vegetable matter.

Infection might also take place from rats or from horses, in both of which animals the disease has been discovered. Lutz and Splendore have described a spontaneous sporotrichosis of the rat, and an observation by Carougeau, and some recent investigations by Gates Page, Frothingham and Paige point to an unusual form of "epizootic lymphangitis" or "glanders" in horses, met with in North and South America, as being identical with sporotrichium Schenkii.

Personal case.—The patient, J. F—, was a strong, well-built man, aged 50 years, by occupation a labourer. He had lived in Rio, in Brazil, and had lately been employed there as general labourer.

When first seen by me at the St. Bartholomew's Hospital on April 11th, 1911, he had just returned from Brazil. Although the affection from which he suffered had been much ameliorated by the treatment he had received on board ship during the journey to England, there was still enough to suggest the diagnosis of sporotrichosis.

On the right hand and arm, extending from the dorsum of the thumb to the axilla, there was a series of dusky-red, raised, softish

nodules, of the size of a pea to a small marble, and these nodules were connected by a firm, raised red ridge in the skin, evidently a string of thickened lymphatics (Plate I, fig. 1, and Fig. 1). The patient said that in Rio, in February, he had slightly wounded the back of his right thumb, and that the thumb had become inflamed, the inflammation subsequently extending along the whole arm to the axilla. Several abscesses had appeared along the arm, and the whole limb had become much swollen and inflamed. No treatment had done any good until during the voyage home large fomentations had been continuously applied.

The disease appeared to be now quiescent, and the nodules, he said, were becoming smaller, but the case so much recalled the earlier

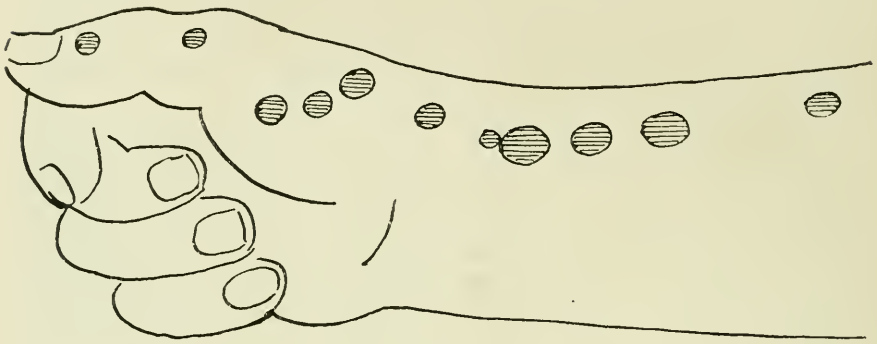


Fig. 1.

examples of sporotrichosis which had been described that I excised a nodule for microscopical examination and inoculated a number of culture-tubes with the now rather inspissated pus from a small abscess. Sabouraud's proof medium, as used for ringworm cultures, was employed, and there appeared in two tubes undoubted cultures of sporothrix.

The *cultures* were at first dirty white, moist, smooth, acuminate elevations with a finely fringed margin. They appeared on the sixth day in the original cultures, on the second day in sub-cultures. They grew rapidly, became dark brown at the centre, and convoluted. At the end of two weeks the cultures were very dark brown in colour, much convoluted at their central part and finely rayed at their margin, which was still pale. The medium used was Sabouraud's proof medium (peptone Chassaing 1, glucose or maltose 3·7, agar 1·5,

PLATE I.

Fig. 1.

Fig. 2.

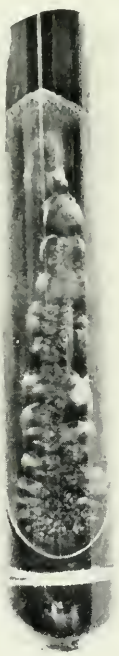


Fig. 3.

To illustrate Dr. H. G. Adamson's Case of Sporotrichosis.

water 100). The cultures were identical in aspect with a culture of sporotrichosis which had been given to the writer by M. Sabourand (see Plate I, figs. 2 and 3).

The fungus.—From the extreme margin of a culture a small portion of the medium containing part of the fringe of the culture was taken and mounted in liq. potassæ. Under the microscope the fungus exactly corresponded with the description given by American and French authors.* There were slender, pointed mycelial threads,

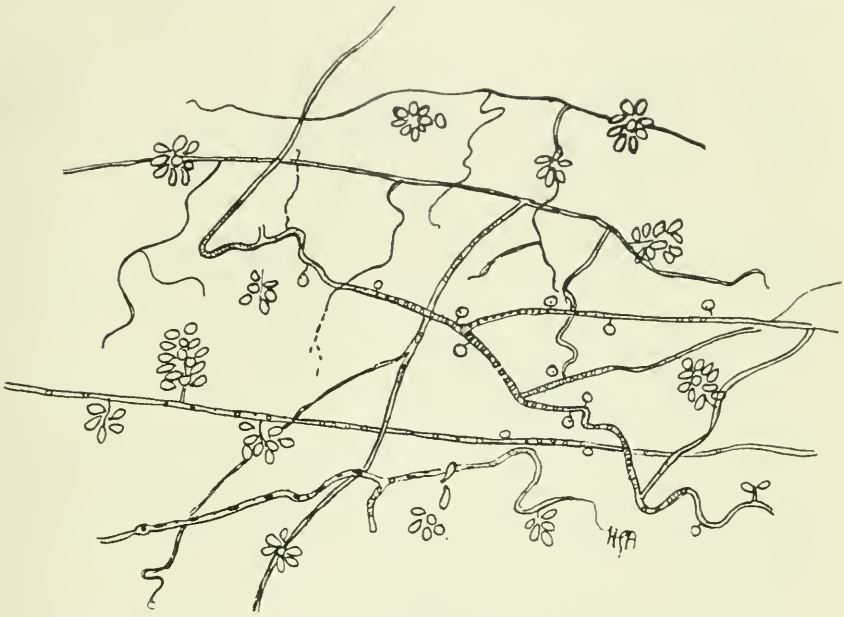


Fig. 2.

sometimes branched, and with oval and rounded spores, attached to the mycelium singly or in groups by a fine pedicle (see Fig. 2).

Pathological anatomy.—The lesion removed from the fore-arm was hardened in alcohol and cut in paraffin, and sections were stained by Mr. J. E. R. McDonagh, who kindly furnished me with the following report:

"Beneath the epidermis extending into the subcutis there is a

* The morphology of the fungus is best studied in hanging-drop cultures or by the "technique des lames sèches," of De Beurmann, by which the fungus is made to grow on slides very thinly covered with culture medium. (See *Ann. de Derm. et de Syph.*, vii, 1906, p. 856.)

cellular mass, in part largely composed of plasma-cells, which are arranged round about the blood-vessels. The blood-vessels, except for showing a slight proliferation of their endothelium, are normal. In other places, also arranged perivascularly, are a collection of lymphocytes; and here and there the gradual transition between these lymphocytes and plasma-cells can be made out. In other places where the blood-vessels are not obvious is a collection of cells which stain badly and cannot be differentiated—in other words a cellular mass. Where the mass is not diffuse typical giant-cells can be distinguished.

"The giant-cells are not formed from plasma-cells, but from epithelioid cells, the origin of which in this case can by no means be clearly made out, but in places they appear to originate from endothelial cells. The plasma-cells show no variation from the normal.

"The fungus, which appears green in section stained with pyronin and methyl-green, is found very sparsely distributed. In one field a piece of jointed mycelium is seen lying in a non-cellular, faintly stained granular mass, around which the cells are few and far between (see Plate II, fig. 1).

"In Plate II, fig. 2, a piece of mycelium ending in a club-shaped spore is seen in the centre of a giant-cell.

"In Plate II, fig. 3, pieces of mycelium are seen, some ending in round-shaped bodies, which may probably be accounted for in the position they are lying when viewed under a microscope. Again intra-cellular.

"The fungus is only found in that part of the infiltration which is sparsely cellular and takes the stain badly. The granular masses are very probably broken-down giant-cells."

As already stated, the fungus has not hitherto been clearly demonstrated in sections of human lesions, and when found in the experimental lesions of the rat it occurs as ovoid bodies (the globular form of De Beurmann) and not as spores or mycelium. This is perhaps what one would expect, namely, that to overcome the resistance of the tissues some special form of the fungus would be developed other than the more simple mycelial form. It is difficult, however, to imagine what the appearances seen in Mr. McDonagh's beautifully stained sections can represent other than the mycelium of the invading organism. And it should be pointed out that

PLATE II.

Sections of sporotrichosis showing mycelium stained pyronin-green by Mr. J. E. R. McDonagh.

To illustrate Dr. H. G. Adamson's Case of Sporotrichosis.

although numerous methods of staining have been employed with the object of demonstrating the fungus in sections, no one appears hitherto to have used pyronin and methyl-green.

Mr. J. E. R. McDonagh also carried out the following examinations:

Serological examination.—(*a*) The serum of the patient deviated complement in the presence of a saline extract of a two months old sporotrichosis culture on maltose and glucose agar. There was no fixation of complement in the control tubes, and in syphilitic sera which had given a positive Wassermann's reaction hæmolysis was complete when sporotrichosis antigen was used.

(*b*) The agglutination test was negative, since agglutination only occurred when equal parts of serum and spore-emulsion were used, and normal serum was capable of doing the same.

The spore-emulsion was made from a one month old culture (glucose and maltose agar). The growth was well pounded up in a mortar with saline and filtered through moist filter-paper, which allows only the spores to pass. Then various dilutions of the sera were made mixed with the emulsion, and examined under the microscope.

Summary.—In this case we have a typical example of sporotrichosis of the lymphatic type as first described in America by Schenk. The infection took place in Brazil. Pure cultures of sporotrichium were obtained from the lesions when already involuting. The patient's serum gave a positive reaction with the Wassermann test, using a culture from a French case as the antigen. A short-jointed mycelium has been demonstrated for the first time in pyronin and methyl-green stained sections of the lesions (by Mr. McDonagh). The lesions (already involuting) cleared up entirely with the administration of iodide of potassium.

References.

(A) *Original papers by American observers:*

Schenk.—"On Refractory Subcutaneous Abscesses caused by a Fungus possibly Related to Sporotrichia." *Johns Hopkins Hosp. Bull.*, 1898. ix. p. 286.

Hektoen and Perkins.—"Refractory Subcutaneous Abscesses caused by *Sporothrix Schenkii*, a New Pathogenic Fungus," *Journal of Experimental Medicine*, 1900. v. p. 77. (Excellent photo-micrographs of the fungus in culture.)

(B) *Original paper by De Beurmann and Ramond in France:*

De Beurmann and Ramond.—"Multiple Subcutaneous Abscesses of Mycosic Origin," *Ann. de Derm. et de Syph.*, 1903, iv, p. 678.

(C) *Further literature:*

References to the now very abundant literature of sporotrichosis to 1908 will be found in the *British Journal of Dermatology*, 1908, vol. xx, p. 301. The following are some of the more exhaustive monographs on this subject:

De Beurmann and Gougerot.—"Les Sporotrichoses Hypodermiques," *Annales de Derm. et de Syph.*, 1906, vii, pp. 837, 914, 993.

De Beurmann and Gougerot.—"Sporotrichoses Tuberculoides," *Annales de Derm. et de Syph.*, 1907, viii, pp. 497, 604, 655.

Bruno Bloch.—"Die Sporotrichose," *Beihefte zur med. Klin.*, 1909, viii and ix, p. 179.

J. Nevins Hyde and D. L. Davis.—"Sporotrichosis in Man," *Journ. of Cut. Dis.*, July, 1911.

ROYAL SOCIETY OF MEDICINE.

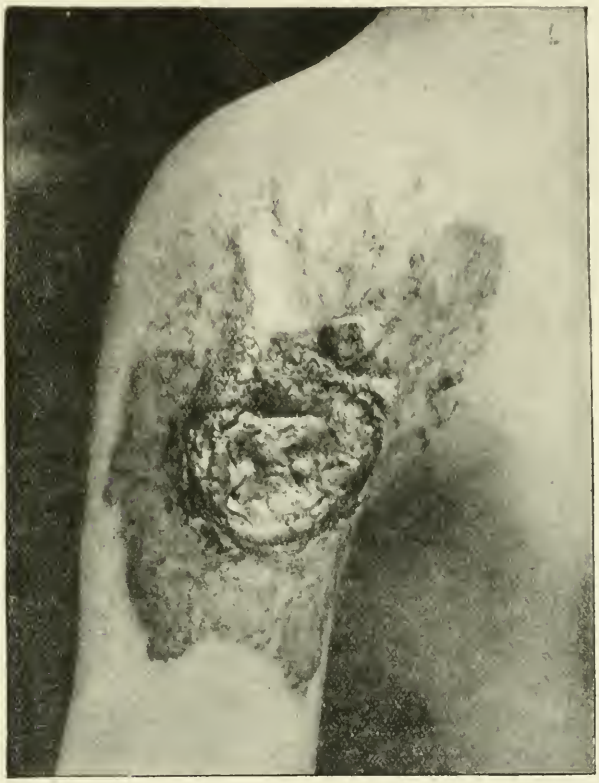
DERMATOLOGICAL SECTION.

At a meeting held on Thursday, July 20th, Dr. Colcott Fox, President, in the Chair,

Dr. Adamson showed for Dr. Iredell a case of *epithelioma on Lupus vulgaris in a girl of thirteen*. A. L—, aged 13 years. The patient's father died of phthisis, but no other history of tuberculosis in the family was obtained. When two years old she had measles, and a few months later red patches started on the left shoulder, buttocks, and right leg. These got larger, and patient was taken to various hospitals for treatment. When seven years she was operated on at the Westminster Hospital, when all the patches seemed better, but they recurred and varied very much. In March, 1910, she went to Guy's Hospital, and had eight applications of X-rays between then and August, when she gave up attending as she was much better. In May, 1911, she came up again as she was not so well and had seven more applications of X-rays at intervals, the last being on July 11th, 1911. When seen on June 20th there was no sign of any malignant ulceration. Each application of X-rays had been of ten minutes duration, the anode being kept at 7½ in. from the patient and $\frac{3}{10}$ milliampère was run through the tube. No sign of any redness, etc., due to X-rays was ever noticed.

When seen on July 20th patient said she had had a sore place

behind her shoulder for three weeks. An ulcer rather larger than a half-crown-piece was present behind the left shoulder and on the upper arm. The floor was covered with a foul-smelling discharge. The margin was wide and raised, of a dull red colour, and bled easily. The surrounding area was red, and apple-jelly colour appeared on pressure. Several large, hard, moveable, painless glands were present in the axilla but none in the supra-clavicular region.



The PRESIDENT showed *water-colour drawings of the scalp and body of a child,* who was suddenly attacked with acute pityriasis of the scalp and a descending erythemata-squamous macular eruption over the face, neck, greater part of the body and limbs. It started about three weeks after the scalp had been X-rayed for ringworm, and extended rapidly; it was easily controlled and cured. Several similar cases had been observed in the Downs School of the Metropolitan Asylums Board. An impetigo of the scalp occasionally follows

raying in exactly the same way. The explanation probably is that the scalp is previously infected, and then the X-rays sets up a slight active congestion, which renders the soil more vulnerable, and a microbe then grows rapidly.

Dr. ADAMSON said that these eruptions were not uncommon in the out-patient department of a children's hospital independently of X-ray treatment. He was accustomed to call them "acute seborrhœic dermatitis." Always in these cases the scalp had been scaly or crusted over the vertex for a long period, when, suddenly, without apparent reason, an eruption burst out, first on the rest of the scalp, the face and the neck, then over the whole body. The eruption was of the type usually described as "seborrhœic dermatitis," and consisted of oval and rounded patches made up of small, red, follicular, scale-topped papules. The eruption cleared up rapidly on the application of a mild sulphur ointment. The eruption was probably due to a mild form of staphylococcic infection. He agreed with Dr. Colcott Fox that the occurrence of the eruption after X-ray treatment of the scalp was due to the fact that an already existing "seborrhœic dermatitis" of the scalp was given a fresh impetus by the lowering of the resistance of the skin of the scalp by the action of the X-rays. As Dr. Fox had pointed out, a similar thing happened when a child with impetigo contagion was X-rayed for

ringworm of the scalp, and there was a rapid spread of Impetigo over the whole scalp. A child with Impetigo capitis or with marked seborrhœic dermatitis of the scalp should not be X-rayed until these affections had been removed by treatment. As a routine treatment a mild antiseptic should be applied to the scalp after X-raying, and Sabouraud's lotion (tinct. iodine 1 part, methylated spirit 7 parts) was perhaps one of the best.

Dr. MacLeod said he had on several occasions noted the occurrence of more or less severe seborrhœic dermatitis and ordinary impetigo of the scalp in connection with the X-ray treatment of ringworm. These forms of dermatitis usually developed about ten days after the exposure as the resistance of the scalp lowered, as a result of the exposure to the rays. To avoid this he found it advisable where any evidence of seborrhœic dermatitis existed, or where impetigo as well as ringworm was present, to thoroughly clean the scalp and to apply a mild sulphur and salicylic ointment previous to the X-ray exposure, and after the exposure to apply daily either carbol-glycerine (1 in 8) or Sabouraud's iodine preparation.

Dr. Whitfield called attention to the fact that if patients were seen twenty-four hours or less after X-raying with pastille doses the skin was often quite red. This was certainly not due to heat from the anticathode, as he used a water-cooled tube. It was also almost certainly not due to X-rays, as the redness usually faded very rapidly, and had nothing in common with the X-ray dermatitis. He found it more marked with high than low tubes, and believed it was due to a static discharge.

The President brought a hale old man, aged 77 years, suffering from an *epithelioma of the back of the left hand of two years' duration.* When first seen there was an ulcer about the size of a five-shilling-piece, but little depressed, and set in a white, hard, solid, smooth bordering. It was diagnosed as a rodent ulcer, on acount of its special aspect and long duration without any signs of dissemination. A tiny piece of the border was removed, and microscopically the growth was pronounced to be an epithelioma and not the form known as rodent ulcer. Amputation of the limb seemed to be required for a possible cure, as the underlying parts appeared to be considerably involved. The patient, however, would not part with his arm after seventy-seven years' use. Dr. Worrall has given him two full pastille doses of X-rays, and there is a decided improvement. Some of the ulcer has almost healed, and the solid border is much softer.

Dr. Dawson said he had a case in which the condition was considered to be rodent ulcer, and X-rays practically cured it, except a small portion, and that was cleared up by the application of CO_2.

Dr. Pernet said he remembered a similar case in a sailor, before the days of X-rays, and amputation was done. That patient had been using a largely advertised ointment for a considerable time.

Dr. Graham Little showed (1) a case of *macular atrophy associated with Lupus erythematosus*. The patient was a young lady, aged 26 years, sent to the exhibitor by Dr. Cave, of Bath, to whom he wished to express his thanks for permission to show the case. All the fingers of the hands were congested and reddened from the tips to the middle; the skin was in addition thickened and the diagnosis of Lupus erythematosus was made; a patch of congested skin strongly suggestive of this diagnosis was present also upon the face. There were numerous telangiectases on both the cheeks below the malar eminence. The symptoms thus ascribed to Lupus erythematosus had dated from one year, but upon the back of the shoulders and upper part of the trunk there were a number of circumscribed circinate patches the size of a threepenny-bit of atrophy of the skin, which was colourless, depressed and shrunken. These had been noted for two years and the recollection of how they had begun was very uncertain and unsatisfactory. There were some of these patches, probably more recent, in which redness was present, and it was a question whether the atrophic areas were the result of earlier Lupus erythematosus in these sites.

There was a history of tuberculosis in one maternal cousin, but no personal history of any illness except a dubious arthritis three years ago which was considered rheumatic. The urine did not contain albumen. Syphilis could probably be excluded.

Dr. Pringle suggested that the atrophy might be the result of the absorption and spontaneous cure of patches of poorly developed Lupus erythematosus on the back, although he had never observed atrophic scarring of precisely the same type in the same connection. The situation was a common one for satellite patches of the disease, as was pointed out many years ago by Sir Jonathan Hutchinson. He did not doubt the accuracy of the diagnosis of Lupus erythematosus on the face and hands.

Dr. Sequeira expressed his agreement with Dr. Pringle. He had under care at present two cases of Lupus erythematosus, in which characteristic lesions were scattered over the shoulders in exactly the same area as in Dr. Little's case. One of the patients had had deep scarring in that situation.

Dr. Whitfield pointed out that the area involved was that which would be only slightly covered or not at all by a summer blouse, consequently the sun might burn through. The sun might not cause the condition, but it might determine its site.

Sir Malcolm Morris said he had seen the condition develop as the result of exposure to the sun's rays. When Lupus erythematosus was imminent such a cause might determine the situation in which it appeared. He had seen a case of

Lupus erythematosus on both cheeks which was almost well, but upon exposure to the sun another attack developed on an exposed part, the original lesions remaining well.

The PRESIDENT said he could understand a source of irritation to the skin determining where the Lupus erythematosus should appear, but he did not think such irritation was causative. The condition was said to be rarer in hot climates.

Dr. DAWSON said he saw a distinct case of the condition in a Territorial a short time ago. He was in camp last summer, when he got badly burnt on the nose and face by the sun, and since that time he had suffered from Lupus erythematosus in that region.

Dr. GRAHAM LITTLE, in reply, said he did not regard the condition at first as Lupus erythematosus. It was not red at all, and the redness now seen was only temporary.

(2) A case of *folliculitis decalvans* in a young lady, aged 19 years, who was at present entering the profession of nursing. She had begun to shed the hair five years ago, and the process had continued slowly but progressively since then. The destruction of the hair had apparently taken place by inflammation of individual follicles; there were no wide areas of baldness, but a diffuse irregular destruction over a large part of the scalp. In individual instances a thickening and slight redness could be seen of the orifice of the diseased follicle, so that a tiny collarette could be identified surrounding the hair, and it was this circumstance which, perhaps, justified the name given to the disease. There were no large areas of cicatricial atrophy, as in the "pseudo-pelade" of Brocq. There had, on the other hand, never been any pustulation of the follicle, as in the type associated with Quinquaud's name, and it was difficult to choose between the possibilities of nomenclature in these cases.

The prognosis was, in the exhibitor's opinion, bad as regards ultimate restoration of hair, and he invited opinions on this point.

Stumps had been removed for examination, and no fungus had been found; the possibility of an endothrix ringworm had been borne in mind. The Wassermann reaction had also been tried and found negative.

Dr. WHITFIELD remarked that in Brocq's pseudo-pelade every hair within the affected area was destroyed as the process reached the follicle. In the present case there was a rather diffuse baldness with some hairs persisting in the affected areas. He agreed with those observers who thought that this was not a cicatricial case. Dr. Whitfield believed from a histological study that the pseudo-pelade in small circumscribed areas was in reality a herpetiform scleroderma of the

scalp, and drew attention to the fact that in Brocq's exhaustive article on the subject one of the cases mentioned had sclerodermia elsewhere.

(3) *A case for diagnosis.* The patient was an engine-driver, aged 60 years. Up to twelve months ago he was in good health. At that time his skin began to become deeply pigmented on the neck, face, and dorsum of hands, and he lost weight rapidly, so that he lost in the twelvemonth just 6 st., his previous weight having been 14 st. 4 lb., his present weight a little over 8 st. His skin is generally pruritic, especially about the chest and back; careful search for pediculi proved fruitless. The pigmentation at present is deepest on the face, neck, back of hands, forearms, axillæ, shoulders, abdomen, about the arms, in the popliteal spaces, and on the knees. The pigmentation is patchy, not universal; in its deepest tint it is the colour of walnut stain with a slightly yellowish blend. Pigment has apparently been deposited along the line of flexure of the palm and slightly on the mucous membrane of the lips. The conjunctivæ are slightly yellowish, but not the lemon yellow of jaundice. The liver is much enlarged, its edge coming down to the umbilicus; there are no excrescences to be felt on its surface or edge. There is no abdominal swelling and no œdema. The pulse is well sustained and firm. There is albumen, a trace, but quite definite, in the urine, but no sugar; specific gravity 1012. Gmelin's test for bile proved negative. The eyebrows were thin, but the hair on the scalp was not scanty for his age. He complained of no pain or inconvenience except itching; there was no nausea or vomiting, no history of jaundice. The patient in some respects showed a strong general resemblance to Dr. Sequeira's case reported in the *Transactions of the Royal Society of Medicine*, December, 1910.

The pigmentation was not unlike that of Acanthosis nigricans, but there was no thickening or rugosity of the skin and no general eruption of warty growth; there are a few quite flat, possibly warty tumours on the left forearm, about five in all. These were not, perhaps, enough to allow of the diagnosis of Acanthosis nigricans being definitely offered, but it was a possible explanation that the pigmentation had preceded the warty development. The sites of pigmentation were those of Acanthosis nigricans. Addison's disease had been thought of, but the absence of all visceral pain and the

excellent pulse seemed to contradict this suggestion. It was hoped to admit the patient to St. Mary's Hospital and report later, when a more complete examination of the blood and other aspects of the case would be made.

Dr. Sequeira said that in the remarkable cases of pigmentation which he showed some time ago he had had the advice of Dr. O. Grünbaum in determining whether the adrenals were affected. The blood-pressure was carefully observed, and then adrenalin was administered. If the pigmentation were due to adrenal insufficiency the administration of adrenalin would raise the blood-pressure, but it could not do so if the adrenals were normal. In Dr. Sequeira's case the administration of adrenalin had no influence on the blood-pressure. This patient also had a remarkable diminution in the red corpuscles of the blood with poikilocytosis. Under subcutaneous injections of arsenic the patient had greatly improved.

Mr. J. E. R. McDonagh, F.R.C.S., showed a case of *syphilitic affection of the eighth nerve*. L. M—, female, aged 35 years, came up to St. Bartholomew's Hospital, July 4th, complaining of a rash on her legs.

Two years ago the patient contracted syphilis, and was treated for eight weeks with inunctions in the General Hospital, Yarmouth. Before she was admitted the secondary rash had spread all over her body, and while the patient was in the hospital she developed double iritis.

Two months after leaving the hospital condylomata appeared around the anus and between the toes.

Since then she had had no treatment of any sort or kind. The present rash was of nine months' duration, and limited to the arms and legs, in parts scaly and psoriasiform in character, while elsewhere, especially around the ankles, were grouped circular lesions of papules, deeply pigmented, characteristic of a recurrent syphilide. On the sole of the right foot was a painful superficial ulcer with much inflammation around.

On examination the pupils were found equal, not quite circular, the left less so than the right, and both reacted to light and accommodation. There was syphilitic leucoderma of the neck.

It was noticed when addressing the patient that she did not seem to hear very well, and on inquiry she stated that she had been deaf on the right side for six months.

This deafness had come on gradually and was getting worse, and at the same time as it appeared noises in the ear were experienced,

and the patient was much troubled with attacks of giddiness which prevented her from going out.

She always had the feeling as if she was going to fall forwards, which really happened on one or two occasions.

The giddiness and vomiting were worse on getting up in the morning, and the latter occurred during the day, always quite irrespective of food. These symptoms, except the giddiness, were increasing in severity. When first seen there was slight nystagmus, which had since disappeared. Menstruation was regular, and the last time was three weeks ago.

Examination of ears showed stenosis of left external auditory meatus of old standing; no defect of hearing; marked reaction to the caloric test in one minute at 115°; patient fell to the right; electrical reactions normal.

On the right side hearing was diminished; no artificial Rhombergism or nystagmus was produced by syringing for three minutes with water at 118°; the electrical reactions of the vestibular nerve were sluggish, but had not quite disappeared. The result of the examination points to inflammation of the trunk of the eighth nerve on the right side affecting both its cochlear and vestibular branches. The condition was not a very uncommon one, and always occurred in the secondary stage of syphilis and usually within a year after infection.

It was usually overlooked, but had lately been brought to the front since observers had noticed its occurrence after the use of "606" and looked upon it as a toxic effect of the drug. Others, again, had recognised it as a not unusual symptom of syphilis, and rightly so too, since this patient has never had "606," and it is a condition which is amenable to treatment, be it mercury or a second injection of "606." Therefore it must be regarded as a syphilitic manifestation of the nature of a neuro-recurrence, and it could only be avoided by early and adequate treatment.

For the case the exhibitor was indebted to Dr. Adamson, and for the careful examination of the ears to Mr. Sidney Scott.

Dr. Whitfield said he had recently had a patient in hospital in whom deafness and giddiness had come on very acutely about six months after infection. The patient was under active mercurial treatment at the time, and all the other, rather severe, symptoms had disappeared very favourably, so that it was a great disappointment when the ear symptoms had developed. The patient was taken in and infused with salvarsan intra-venously, but it had absolutely no effect, either

beneficially or otherwise, the patient remaining practically stone deaf with both ears.

Dr. SEQUEIRA said that the reason dermatologists had had their attention called to this condition was that patients suffering from chancre and early secondaries were admitted into the wards of a hospital for the administration of salvarsan, whereas formerly they were all treated as out-patients.

Sir MALCOLM MORRIS said that when he was house-surgeon at the Lock Hospital there were a number of patients who were detained, and among them every now and then were seen cases of giddiness, leading to falls. At that time, owing to imperfect knowledge, the seizures were supposed to be epileptic, and not to be connected with the syphilis.

Dr. J. M. H. MACLEOD showed *specimens of hair from an aboriginal Indian girl* which were sent by Dr. Minett from the Government Bacteriological Department of British Guiana, and came from the Rupununi district. The hairs were characterised by the presence on the shaft of hard nodules varying in size from minute specks like particles of grit up to small pins' heads, tending to be oval in shape, brownish-black in colour, and situated either on the side of the shaft like a nit or forming a concretion around it. According to Dr. Minett's note they affected entirely the extra-follicular portion of the hair. They varied in number from one to ten or more, and were situated close to each other or at irregular intervals. They were entirely outside the hair-shaft at first, but their presence eventually caused a breaking up of the cuticle, a fraying of the cortex, and rendered the hair liable to fracture opposite them.

On microscopical examination of the hairs softened in liquor potassæ the nodules were found to consist of large spores of a peculiar fungus which were recognised as probably that to which Behrend has given the name of "Trichosporum giganteum." In the small nodules the spores had a strikingly regular arrangement. At the periphery of the nodule there was a pallisade layer of oblong spores from 10 to 12 μ in length arranged at right angles to the hair-shaft, while next the hair the spores were irregular and tending to be polygonal. In some instances these had a peculiar fan-like arrangement of rows of spores radiating from a central base. They appeared to be held together in a mass with some viscid cement substance which formed a sort of capsule enclosing them, and they presented a yellowish appearance owing to a diffuse colouring matter in the protoplasm and the presence of pigment-granules. In the larger nodules the spores

were not so marked, and they formed a mosaic or honeycomb-like arrangement with a few oblong regular spores at the periphery. No definite mycelial threads were detected. A number of attempts were made to cultivate the fungus, a culture being obtained on maltose agar of a chocolate colour somewhat suggesting that of an endothrix ringworm. This culture is possibly that of the fungus but is not yet fully worked out, and the exhibitor will report at a future meeting further experiments on the subject.

The condition was obviously a form of trichosporosis and probably that type which is familiar in the valleys of Cauca in Columbia, and is known there on account of the hardness of the concretions as piedra. It has already been described in this country by Sir Malcolm Morris, and is closely allied, though possibly due to different species of fungi, to Piedra nostras (Unna and Behrend), Tinea nodosa (Crocker and Pernet), and possibly to Chignon fungus (Beigel and Fox), but is quite distinct from the condition known as leptothrix, which affects chiefly the hairs of the axillæ.

The exhibitor is indebted to his clinical assistant, Mr. F. C. Davies, for valuable help in cultivating the fungus.

Mr. Beddoes asked whether the condition was that first described by the well-known writer Beglay. He believed the word "shingle" was applied to it because the workers, when passing it through the fingers, said it felt as if sand was upon it. He looked the matter up some years ago and found that a fair number of cases had been reported in England, and certainly in Europe.

Dr. Sequeira showed a case of *Alopecia areata* in a syphilitic subject. The patient, a healthy-looking man, aged 47 years, contracted syphilis three years ago. He was treated with pills in Glasgow, and has continued under treatment intermittently ever since the primary sore was noticed. The primary sore upon the penis broke down six months ago, but healed up soon after.

About the same time a patch of baldness appeared, and this gradually extended until it was nearly three inches across. During the past month a number of smaller bald patches have developed. When shown there was a large bald area 3 in. by 2½ in., occupying the left vertical region. This patch, which had been quite denuded of hair, was covered with fine white down. Over the occipital and temporal regions there were numerous small bald areas, none of them

larger than a shilling. The latter more closely resembled the true Alopecia syphilitica.

The Wassermann reaction was positive.

The exhibitor thought that the case would be of great interest to the members in view of the fact that Dr. Sabouraud had reported similar cases. Dr. Sequeira had had a number of cases of Alopecia areata examined by the Wasserman test, but this was the only instance in which a positive result had been obtained. He was inclined to think that it would be better to call the condition Alopecia areata in a syphilitic subject rather than Alopecia syphilitica.

Mr. Arthur Shillitoe showed (1) a case of *ringworm of the toe-nails*. The patient, a native of India, and aged 36 years, stated that the condition of the toe-nails started in the right big toe when he was in Europe in 1898. During the year 1900 to 1907 he appeared to have had a good deal of malaria. In 1901, and again in 1910, the skin of palms, soles and insteps peeled off with an intense burning sensation, the eruption on each occasion starting in large rings.

In February of the present year he was informed that he undoubtedly had syphilis, and was treated for about six weeks with mercury ionisation, and again from April 8th to the end of the month.

He was badly salivated without any amelioration of the condition of the insteps or nails. He never, so far as he knows, had a chancre.

July 1st, all the toe-nails are affected, being brittle, friable, and of a dirty-grey colour, together with some peeling of the skin of the insteps.

Having had no mercury since the end of April, Mr. McDonagh was asked to make a Wassermann blood-test. The result was negative, and in addition he took scrapings of the nails, and later sent the following report:

"Examination of nail scrapings with KOH. showed an endothrix ringworm. Attempts at cultivating the same failed, and only penicillium glaucum grew in two tubes on glucose agar."

There has been considerable improvement under treatment.

Mr. McDonagh said he obtained the fungus from scraping the nail of the big toe. There had been patches in the groin. The patch on the hand came subsequently to that on the feet. For treatment, after the scraping, linimentum iodidi and 20 per cent. caustic potash (æq. partes) were applied.

(2) A case of *corymbose syphilide*. This gentleman, aged 26 years, acquired syphilis in November, 1910, and three weeks later was placed under treatment.

At the end of December he had a very general papular syphilide. He was first seen on June 20th, when the remains of the papules were still evident. Each papule was surrounded by a ring the size of a florin of small follicular papules.

July 11th he received an intra-venous injection of "606."

The eruption was much improved, but enough remained to show the somewhat unusual form it assumed.

Dr. ADAMSON asked whether there was any Leucoderma cervicis, which he said is so often found associated with this condition.

Mr. SHILLITOE said it was very well marked, though when first seen on June 20th it was only present in the form of a dark, pigmented collar, the achromic areas not appearing until after the use of the "606."

BRITISH MEDICAL ASSOCIATION, ANNUAL MEETING AT BIRMINGHAM, 1911.

REPORT OF PROCEEDINGS IN THE SECTION OF DERMATOLOGY.

THE Section held its meetings under the presidency of Dr. James Galloway, in the University Buildings, Edmund Street, on the mornings of July 26th, 27th, and 28th. The attendance was good, especially on the second day, when a joint meeting with the Therapeutic Section had been arranged. Many cases of interest were exhibited, and some very interesting exhibits provided in the sectional museum, chief among which must be mentioned the beautiful wax models of Dr. Cranston Low and of Drs. Stopford Taylor and McKenna.

Wednesday, July 26th.

The PRESIDENT, in opening the proceedings, said that the programme selected was a very wide one, and afforded opportunity for the narration of their experiences by many classes of practitioners. Their colleagues in Birmingham had helped to add interest to the meeting by bringing up a most interesting collection of cases. In the matter of the exhibition of cases the Dermatological Section had

given the lead to other sections, which were now following their example.

Dr. T. Colcott Fox (London) then proceeded to open the discussion on "The Vascular Disorders of the Skin and their Relationship to other Morbid States."

Dr. Fox, commenting on the wideness of the subject, stated that he would deal with the three great symptomatic groups of eruptions in which the blood-vessels were specially involved, namely, erythema, purpura, and urticaria, and also with some phases of lupus erythematosus.

In dealing with the group of erythemata, after some preliminary remarks on the definition of the term, the speaker reminded his audience of Willan's grouping of the exanthemata or rashes, and noted that the close clinical analogy and relationship of many of the eruptions could still be recognised; he believed that, in spite of Hebra's division of these eruptions into the purely hyperæmic and into the exsudative group, both these groups of cutaneous reactions constituted one great family. He then proceeded at some length to deal with the clinical and ætiological features of the hyperæmic and exudative forms of erythema, and laid stress on the fact that the "rash was only one feature in a more or less marked constitutional disturbance, which might implicate various organs."

He noted that nephritis, endocarditis, severe gastro-intestinal disturbance, pneumonia, pleurisy, arthritis, and even hemiplegia might occur, and quoted Osler's case of chronic hæmorrhagic erythema, in which fibrotic changes appeared in the liver and other organs. After describing the pathological anatomy of the skin-lesions, he dealt with the theories which had been advanced to explain their production.

Dealing with purpura, Dr. Fox mentioned the tendency to the exudation of red blood-cells into erythematous lesions so as sometimes to mask the original lesion. He also noted that purpura might be met with in all systemic microbial diseases, whether primary or secondary, acute or chronic. The microbes of the infections had been found in the blood and in the eruption in many instances. In other cases no micro-organism had been found, and the eruption had been considered to be due to toxins. A third group consisted of toxins of non-microbic origin such as occurred in the toxæmia of pregnancy. Various other factors in the ætiology of purpura were discussed. The constant

presence of a slight degree of pyrexia and the occasional presence of lymphocytosis were said to be suggestive of an infective or toxic process. Referring to the pathogeny of purpura, the speaker remarked that this was a very vexed question, owing, no doubt, to the vast number of conditions in which the purpuric lesions appeared. Alterations in the blood, such as changes in coagulability and in the blood-cells, were referred to, and Hayem's experiments on the production of blood changes favouring thrombosis and embolism were mentioned. Vaso-dilatation produced by toxins was also discussed, and the speaker questioned whether simple diapedesis explained the hæmorrhage in some cases. Further questions as to the action of toxins on the vaso-motor centres or on the vessel wall were discussed.

Dr. Fox then proceeded to detail the symptoms and ætiology of urticaria. In dealing with the pathology of this condition he mentioned that in recent years some observers had favoured the opinion that the wheal was of an inflammatory nature produced by the direct action on the vessels of the exciting influence and not a reflex vaso-motor disturbance: he expressed himself unconvinced of this. He also called attention to Wright's work on the state of the blood in this condition.

Finally, dealing with Lupus erythematosus, he described in detail the histological changes noted in this disease. He noted the difficulty with which some cases could be diagnosed from the erythemata, but called attention to certain differences, notably the rarity in children and the preference for females in the former disease. He called attention especially to the co-existence of some phase of tuberculosis, and also to the marked family history of this disease in many cases, quoting the experience of Sequeira, Pick and others, and, concluding, mentioned the experiments of Gongerat, Benrmann and Arndt with reference to the inoculation of Lupus erythematosus material into animals.

Sir William Osler (Oxford), who followed, congratulated Dr. Fox on his exhaustive presentation of the subject. As a general physician he saw more of the medical than of the strictly dermatological aspect of the cases. He referred especially to the visceral complications of the erythemata, the seriousness of which could be appreciated by anyone who glanced over the tabular list of twenty-nine cases which he had reported, seven of which had died. The interchanging character of the skin-lesions had impressed him; the same patient had shown in different attacks purpura, urticaria, and angio-neurotic œdema. The

visceral features were varied. By far the most common were the abdominal attacks, either gastric crises, vomiting, and severe pain or simple intestinal colic. The importance of the recognition of this feature depended on the fact that the cases were often mistaken for appendicitis. Many had been operated upon, and the surgeons had now shown us the nature of the lesion—an acute œdema or hæmorrhagic effusion into the wall of the stomach or intestine. Sutherland had collected a series of cases from the literature, some of which had been mistaken for intussusception. A point of interest was that the patient might suffer for years with the abdominal attacks without any skin-lesions. In one of Professor Osler's patients, a boy, aged 10 years, attacks of colic with slight fever had persisted from his first year, and it was several years before any skin-symptoms appeared. Next in order of frequency, probably even more serious, were the kidney complications. Fourteen of his series of twenty-nine cases had albumen in the urine with tube-casts, and in seven blood with all the features of acute nephritis; five of the seven deaths in his series were due to uræmia. The respiratory complications were rarely serious, except in angio-neurotic œdema, in which there had been a number of cases of death from œdema of the glottis. Endocarditis had not been common in his series, but was a well-recognised complication of the arthritic or rheumatic form of purpura. Some obscure cases of erythema had remarkable pulmonary complications. It was well known how asthma and urticaria were associated. Professor Osler quoted a case in which the disease began with erythema over the cheeks and nose, pneumonia occurred during a severe outbreak, and subsequently the patient died of acute nephritis. Another case had pericarditis and pleurisy. Cerebral symptoms have occurred in a few rare instances; Professor Osler quoted the case of a girl, aged 16 years, who had had periodic attacks of purpura with nausea and abdominal pain from her seventh year. She developed hemiplegia and aphasia, and recurring convulsions associated with an outbreak of purpura. Dr. Cushing, on operating, found a tense dura and congestion of the brain and pia, but no clot. The patient died in coma three days later. Professor Osler finally referred to the remarkable cases of recurring purpura, chiefly of the legs, followed in the course of years by sclerosis of the liver, spleen, and pancreas, bronzing of the skin, and the general picture of hæmachromatosis. Finally, he referred to the important fact that gastro-intestinal crises might occur in hæmophilia, a point of great importance, as an operation in these cases was so dangerous.

Sir Malcolm Morris (London) said that the subject was much too wide to discuss in the short time at his disposal; he proposed, therefore, to deal with some practical and clinical points. He thought for this purpose it was useful to divide the cases up into two groups—(*a*) those which ran a short course, (*b*) those which ran a long course or were recurrent. In the first group considerable difficulty might arise in diagnosis, notably in cases which resembled the acute exanthemata. He advised that the most serious view of the case should always be taken, and that cases should, if necessary, be isolated till a certain conclusion could be arrived at. Difficulties in diagnosis might also arise in angio-neurotic œdema cases when no previous history was forthcoming. Long-standing or relapsing erythematous eruptions were often obscure in their pathology. He quoted the case of an engine-driver who was under his care, and who was admitted to hospital in the first instance for a doubtful eruption on the trunk, which subsequently developed into an Erythema iris; later a universal eruption of the Pityriasis rubra

type developed; subsequently the patient became insane and died in an asylum. At the autopsy one kidney was absent altogether and the other was of enormous size and had the characters of a large white kidney. No changes had been noted in the urine previous to death in spite of careful examination, nor were any renal or abdominal symptoms present. He called attention to the fact that idiosyncrasy played a part in these eruptions, and instanced egg-poisoning as an example. In determining the prognosis he thought the presence of renal complications was very important, and advised a careful examination of the urine in all cases. The value of examining the fæces for organisms had yet to be determined, but he had seen marked benefit in some cases of angio-neurotic œdema from the administration of *coli* bacillus vaccine, and in other cases the Plombiére treatment had proved beneficial. He commented on the changes which had occurred in treatment during the time he had been in practice. He noted that more attention was now being paid to obtaining efficient intestinal antiseptics, and depreciated strongly the routine use of aperients now so universally employed.

Dr. Alfred Eddowes (London) referred to some cases in which some definite cause seemed to be present. In a patient aged 85 years an acute attack of urticaria developed after drinking sour beer. This was completely cured by a saline aperient. In a child with Urticaria papulosa and a permanent erythematous patch on one cheek, headache, severe vomiting and constipation occurred; when the bowels acted the latter symptoms disappeared; the motions were very foul, as was generally the case in urticaria. A case of purpuric erythema which he attributed to some temporary toxin in the intestines had been sent to a small-pox hospital as a case of the latter disease, recovered in forty-eight hours as a result of purging. He had seen a case of severe Lupus erythematosus cured by sour milk. A case of Urticaria papulosa complicated by impetigo which had failed to respond to external and intestinal antiseptics recovered quickly under iron and phosphates.

Dr. Leslie Roberts (Liverpool) considered that the classification of cutaneous symptomatic disorders was necessarily imperfect owing to our defective knowledge of the internal diseases which produced them. He distinguished clinically: (1) Angio-neurotic œdemas and erythemata; (2) vascular disorders followed by atrophy of perivascular tissues; (3) vascular disorders followed by cutaneous hæmorrhage. Dealing with Lupus erythematosus he recognised three varieties: (1) The discoid variety limited to small areas such as face and hands; (2) Chronic disseminated variety associated with albuminuria and often with tuberculosis. (3) The forms which were acute from the beginning, were associated with pyrexia and rapid pulse and almost invariably ended fatally. He was of opinion that there was some relationship between Lupus erythematosus and tuberculosis, but that there was not sufficient evidence for believing that the former was caused by tuberculous bacillo-toxins. He thought that the disease was a manifestation of a toxæmia, and that it was connected with disease of the lymphatic glands. Diseases associated with cutaneous hæmorrhage were in some instances associated with disease of the blood-forming organs. He described a case of myeloid leukæmia in which cutaneous hæmorrhages occurred in three forms—(1) petechiæ, (2) contusions, and (3) tumour-like ecchymoses.

Dr. J. H. Sequeira (London) said he would confine his remarks to the consideration of the acute or erythematous form of Lupus erythematosus and its relationship to tuberculosis. He regretted the use of the term "lupus," as it led to

a confusion of ideas. Lupus erythematosus was probably a toxic eruption, and in its acute type indistinguishable clinically from the common forms of erythema, but it differs from the latter in its distribution and persistence. The acute exanthematic type passed by insensible gradation to the fixed and chronic variety, and intermediate cases were met with. Dr. Sequeira quoted cases in which great difficulty arose in determining the cause of the disease. A girl, aged 15 years, suffered from pyrexia for some months, and great fœtidity of the stools. No organism but *Bacillus coli* could be demonstrated. The febrile attacks were accompanied by an erythematous eruption on the butterfly area of the face, on backs of hands and feet, and on the elbows and knees. There was nothing to suggest tuberculosis: urine was always free from albumen. In a second case, also a young girl with typical acute Lupus erythematosus and pyrexia, death occurred, and general tuberculosis of abdominal and thoracic glands was found. Here the evidence pointed to the eruption being a tuberculous exanthem. In a third case, also a fatal one, a young girl presented the characteristic eruption on the face and extremities. The patient had anasarca and albuminuria with tube-casts. At autopsy, acute glomerular nephritis was found. A calcareous nodule was found at the apex of one lung, but the glands were free from tuberculosis. It was probable that the toxæmia which produced the cutaneous eruption also produced the nephritis. There was nothing to suggest previous renal disease. The fourth case illustrated a point brought out by Dr. Fox, viz. that the same toxin might produce erythematous and hæmorrhagic lesions. In this case, the patient, also a woman, had a purpuric eruption, occupying the butterfly area on the face, and also lesions of the same type on the extremities. She died from pulmonary tuberculosis. Dr. Sequeira considered that in the present state of knowledge it is impossible to exclude tuberculosis in a case of Lupus erythematosus, but intestinal toxæmia seemed able to produce an identical outbreak in the skin.

Thursday, July 27th.

A joint meeting was held with the Section of Therapeutics to discuss "Recent Developments in the Diagnosis and Treatment of Syphilis."

Mr. J. Ernest Lane (London), who opened the discussion, stated that he would confine his remarks to the treatment of the disease. In December last he had read a paper in which he expressed the opinion that the new preparation, salvarsan, or "606," was remarkably powerful in the relief of symptoms, but that there was as yet no evidence that it had curative powers equal to the time-honoured preparations of mercury. Since that time he had adopted the intravenous method of administering this drug, but he as yet has seen no reason to recede from the opinion then expressed. Some people had imagined that he was an opponent of the use of the drug, but this was not the case; he had used the drug in over 120 suitable cases, but

did not recommend its promiscuous use in all cases of the disease. He much deprecated the way in which the press, both medical and lay, had encouraged the most extravagant expectations, both of cure and of immunity from danger—expectations which could only lead to disappointment. He anticipated that his own results would be less favourable than those of the military surgeons, who often obtained their cases in the early stages of the disease, and whose patients were strong, healthy individuals, well fed and well looked after, while those attending the civil hospitals were often broken down in health, and often subject to alcoholism.

Salvarsan in most cases checked the ravages of the disease, but he was unable to say that he had yet seen a case cured by the drug. He recognised that in salvarsan we had a drug of great value, and he considered it especially useful in primary lesions, in ulcerations of the tongue, mouth, tonsil, in syphilitic laryngitis and iritis. He further recognised that it was calculated to control the spread of the disease, because its rapid action had effect upon early cases in their most contagious stage. But he wished it to be remembered that "606" was not the only drug for the treatment of syphilis, and he had not deserted the old well-tried remedy, mercury, and still regarded this latter drug as their mainstay.

In early cases, when the diagnosis had been if necessary confirmed by the presence of the *Treponema pallidum*, he recommended an intra-venous injection of "606" followed by a second in ten to fourteen days' time, and then a course of mercury for a period of three years. He quoted the opinion of Neisser as to the importance of continuing mercurial treatment after giving salvarsan.

The speaker referred to the expense attached to the administration of the drug and the necessity of keeping the patient in bed for at least twenty-four hours, and of having a nurse in attendance.

With regard to some of the difficulties experienced he noted in some cases difficulty in getting into a vein, especially in women; in some cases the vein might be missed and extravasation into cellular tissue occur.

In dealing with the dangers of the drug Mr. Lane mentioned two cases under his own observation of very severe syphilis in which death occurred. In one case, a male, aged 27 years, with phagedæna of the penis, who had been treated with calomel injections with no

result, was given 0·5 grm. "606" intra-venously; no improvement took place, and palate and fauces became ulcerated, and death supervened.

In the second case a patient with malignant syphilis improved for a time with calomel injections, but symptoms recurred and he was given an intra-venous injection of 0·5 grm. "606"; vomiting and extreme collapse occurred after the injection, and later intense jaundice developed; delirium supervened, and death occurred on the ninth day after the injection.

Finally the speaker quoted a case, which had occurred in the practice of a friend, of a male aged 30 years, in good health, who had mild symptoms of syphilis, and was at first treated by mercury. As Wassermann reaction was positive after eighteen months' treatment, an intra-venous injection of salvarsan 0·6 grm. was given: slight nausea followed the injection, and later cyanosis and thoracic pain developed; pulse became bad, and in spite of treatment death occurred the same night.

Mr. Lane, in concluding, urged his colleagues to be cautious in administering the drug without having made a careful study of the technique.

Major L. W. Harrison, R.A.M.C., read a conjoint paper by Major Gibbard and himself and illustrated it with a detailed table showing the results, clinical and pathological, that they had obtained with salvarsan in 126 cases; also the dose and manner of administration in each case. The table included all the cases they had had under observation for at least three months; all the clinical relapses; and any cases which were of special interest. No case had been omitted where the results obtained would possibly detract from the value of salvarsan. They concluded that the specific effect of salvarsan was more intense than that of mercury, but it was much too early to speak as to the permanence of results. They had had twenty clinical relapses in 121 cases observed for three to twelve months, and the number in which the Wassermann reaction had returned to positive, after being converted to negative, was much greater. They thought that though a method of administering salvarsan had not yet been devised which would ensure a cure in all cases, there was much hope that salvarsan would rob syphilis of many of its terrors.

They had had no disasters in 650 administrations. Since they had made a practice of preparing the salt solution immediately before autoclaving it, they had noted a very considerable reduction in the number and severity of the reaction following intra-venous injection.

Mr. J. E. R. McDonagh (London) dealt with cases in which cranial nerve lesions had appeared after the administration of "606." Optic neuritis had been noted, but lesions of the auditory nerve were the most frequently reported, producing symptoms of deafness and tinnitus. Mr. McDonagh believed that these cases were due to the syphilitic disease and not to the drug, and instanced a case he had recently shown at the Royal Society of Medicine of a young woman, who had never had "606," but who showed these auditory nerve symptoms. He recommended further treatment by "606" or mercury in these cases. He considered diseases of the liver and kidneys, aneurysms, diabetes, advanced cases of nervous diseases, old age and marasmus in infants as contra-indications to treatment by salvarsan. He thought the pallor and collapse often following injections of "606" due to fall of blood-pressure produced by excessive alkalinity of solution. He recommended subcutaneous injections of camphor in dealing with this condition. He recommended the combination of salvarsan and mercury in the treatment of syphilis.

Dr. Schuster (Aachen) confined his remarks to the treatment of nervous disease and the value of the Wassermann test. This was frequently negative in the case of manifest syphilis. In tabes and general paralysis little could be expected except in the elimination of persisting infection.

Dr. Stopford Taylor (Liverpool) preferred the intra-venous method of injection of "606." He warned his hearers to examine the phials in which the drug was contained, as in one of his cases he nearly injected some of the drug which had oxydised. He had never had any anxiety with any of his cases. He quoted some cases of his which had been treated with salvarsan.

Dr. Otto Grünbaum (London) doubted the possibility of relief in genuine tabetic disease of the cord. He referred to the existence of cases of pseudo-tabes.

Dr. George Pernet (London) considered it very important that the contra-indication to the use of salvarsan laid down by Prof. Ehrlich should be observed. Dr. Pernet agreed with the attitude of the opener of the discussion, viz. that individual cases should be taken on their merits, and that patients should be told exactly how matters stood as to risks. He thought that the investigations carried out by Majors Gibbard and Harrison on patients under control would be extremely valuable to the profession.

Dr. G. H. Lancashire (Manchester) had had satisfactory results with the intra-muscular method of injection of "606"; he used a neutral preparation and injected 0·6 grm. usually. He quoted cases showing the good results obtained.

Dr. J. C. McWalter (Dublin) deplored the fact that the discussion had been entirely concerned with the success of a proprietary article sold at an exorbitant price. Its good effects were due to the large amount of arsenic which could be introduced in this way into the system, and possibly, in tabetic cases, due to its combination with one of the coal-tar derivatives.

Mr. Lane briefly replied.

Major L. W. Harrison, in a supplementary paper, pointed out the importance of making a certain diagnosis in early syphilis. He had examined a long series of cases by the dark-ground illumination method, and found it possible to make a certain diagnosis in a far larger number of cases than was possible clinically.

He produced a statistical table showing the results which had been met with in untreated primary and secondary cases and on treated secondary, tertiary, and latent cases. He also demonstrated the results on the Wassermann reaction, of a course of mercurial treatment, and compared these results with those obtained from patients treated with salvarsan, no case being taken who had had salvarsan within three months of the date of doing the reaction. Major Harrison had done all his Wassermann tests by two methods, the original and Stern's modification, and was able to show the greater delicacy of the latter method. Further, he was able to compare the results of salvarsan treatment favourably with those of mercurial, but expressed no opinion as to its value from the figures produced.

Friday, July 28th.

Dr. G. H. Lancashire (Manchester) read a paper in which he described an unusual case of skin pigmentation. The patient, a woman, aged 31 years, had had a patch of dark skin on the neck since childhood. Lately this had spread rather rapidly to the chest and shoulder on the left side, and had been accompanied by paroxysmal attacks of very severe pain, lasting a few minutes, and seemingly followed each time by a fresh deposit of pigment. The pain disappeared under bromides and local anodyne applications, and considerable absorption of pigment had also occurred. Microscopic examination showed the characters of a pigmented nævus.

The speaker concluded that there must be some neurosis behind this train of events, and noted the likeness to Herpes zoster if one imagined the vesicles replaced by pigment. He felt sure that if one could interpret it aright the case would throw some light on the pathology of pigmentation.

The President (Dr. Galloway) remarked on the association of severe neuralgia with long-standing structural defects in the skin, which in themselves did not suggest the possibility of bringing neuralgia in their train. He mentioned the occurrence of a severe type of neuralgia with plane myoma of the cutis—a rare condition of which he had seen an example recently.

Dr. Eddowes referred to the possibility of arsenic poisoning in such cases, and mentioned a case of extensive Herpes zoster with marked pigmentation in a patient with other symptoms of arsenical poisoning.

Dr. Sequeira asked whether frequent applications in the form of fomentations or other stimulants to the circulation had been used to the painful area, as it was not uncommon for pigmentation to follow such local irritation.

Dr. G. W. Dawson (London) thought there might be some relation between this case and Dermatitis herpetiformis.

Dr. Adamson (London) said that Dr. Lancashire's case reminded him of two cases of unilateral pigmentation he had seen. He thought that the freckling in this case might be of congenital origin, and the fact that some of the pigment had only recently become evident was not against this view.

Dr. H. G. Adamson (London) then read some remarks and showed photographs and cultures illustrating a case of sporotrichosis recently under his care. A detailed account of this case is published in this number of the Journal.

Dr. Cranston Low (Edinburgh) also showed a cast from a case of sporotrichosis recently published by Dr. Norman Walker in the *British Medical Journal*. He also demonstrated cultures and drawings from the same case. He described the microscopic appearances, and pointed out the resemblance to the appearances seen in actinomycosis rather than that of syphilis and tubercle. Attention was drawn to the fact that when cultures were made for diagnostic purposes they should be kept at room temperature and not incubated.

Dr. Otto Grünbaum mentioned a case of the disease which had come under his notice.

Dr. Street also mentioned a case of a patient who developed nodules on the dorsal aspect of the hands and forearms and in addition a number of smaller very irritable papules. Cultural diagnosis had not yet been made.

Dr. Stopford Taylor (Liverpool) read a paper on the treatment of eczema. He defined eczema as a catarrhal inflammation of the skin, and pointed out that secondary infection readily occurred. It was important to convert a moist lesion into a dry one. Treatment in all cases must be directed firstly to removal of morbid products, and, secondly, to protection of the inflamed surfaces from the atmosphere and other sources of inflammation. He recommended the starch and boracic poultices of Jamieson for the former. For the latter he used pastes or ointments spread on wet lint, and faced with moist butter-cloth to prevent adhesion to the skin, and also to act as a drain;

these dressings were kept in place with muslin bandages. They might be used with other applications, such as dermatol or tar. They were specially valuable in facial eczema of children. For squamous eczemas remedies should be associated with massage, gently practised at first.

Dealing with the cause of infantile facial eczema, the speaker claimed that too much soap and water, towelling and imperfect drying were responsible for the condition in the first instance.

For the verrucose type of eczema CO_2 snow had much to recommend it.

Dr. Cranston Low did not agree with Dr. Stopford Taylor's views on eczema. He thought the term "eczema" should be dropped altogether. He thought the affection should be divided into three classes: (1) Artificial dermatitis due to irritants; (2) dermatitis on the top of ichthyosis; (3) seborrhœic dermatitis. He pointed out that the so-called infantile eczema began on the scalp, and affected the parts usually affected in seborrhœic dermatitis. He agreed with Dr. Taylor with regard to the use of masks, but recommended complete fixation of the child to the bed to prevent scratching. He considered the so-called varicose eczema as a seborrhœic dermatitis on the top of a skin devitalised by the abnormal condition of the blood-vessels.

Dr. Adamson thought on the other hand that the term "eczema" should be retained, and that the word "seborrhœic" should be got rid of.

Dr. William Dyson thought that both the terms "eczema" and "seborrhœic dermatitis" should go, and that the term "irritative dermatitis" was to be preferred.

The President (Dr. Galloway) then read a paper on degenerative changes in the blood-vessels and their effects on the skin, showing lantern-slides of the hands of patients with terminal gangrene of the fingers, with neuralgic symptoms of an erythromelalgic nature due to syphilitic disease of the arteries. He described the formation of the thrombus in the diseased vessels, and also showed that the morbid changes occurred in the veins as well as in the arteries. He also showed drawings of a case of Dermatitis repens, in whom the inner coat of the small blood-vessels was very much diseased. Lastly, he demonstrated drawings from a man with syphilitic, tuberculous and alcoholic disease in whom a curious degeneration of the capillaries had taken place on the face and elsewhere, along with visceral disease.

Dr. Alfred Eddowes noted that in Acne rosacea there was fibrositis which

pressed upon the little radical veins, and produced telangiectases in the shape of spider nævi; only local irritation was required to produce an acute eczema.

Dr. Goodwin Tomkinson (Glasgow) read a paper on Pruritus vulvæ. He considered that the majority of cases of pruritus were the expression of a toxæmic state. He described the cure of a patient suffering from Pruritus vulvæ after five or six small X-ray exposures, other treatment having failed. He, however, did not recommend the indiscriminate use of X-rays in this disease.

Dr. G. W. Dawson had seen good results in Pruritus ani from X-ray exposures.

Dr. Adamson recommended doses just short of a "pastille dose" given two or three times at three weeks' interval as giving very satisfactory results.

Dr. Stopford Taylor used prolonged baths of 1 in 16,000 perchloride of mercury in Pruritus vulvæ and ani due to an eczematoid condition. When leucodermia is present the condition was best dealt with by X-rays. He recommended the use of the galvano-cautery in cases where Lichen planus papules were present on the vulva.

The meetings of the Section concluded with a few words from the President, who advised all members of the Section to visit the Sectional Museum. A vote of thanks to the President was proposed by Dr. Stopford Taylor, and the proceedings terminated.

A. M. H. Gray.

SEVENTH INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOGRAPHY, ROME.

Dr. Ciarrocchi, the General Secretary, asks us to make known the postponement of the Congress from September, 1911, until the middle of April, 1912. The delay is due to the fact that many of the foreign committees have found the month of September very unsuitable for their members. The committee of the Congress hope that in spite of this postponement those who have already expressed their intention of being present will be able to attend in April. Those who are unable to do so are requested kindly to inform Dr. Ciarrocchi, 5 Piazza Grazioli, Rome.

CURRENT LITERATURE.

OILY SUSPENSIONS OF SALVARSAN. Pollitzer. (*New York Med. Journ.*, March 4th, 1911, p. 403.)

The advantage of the method consists in the saving of time by having the suspension ready at hand; just as we are in the habit of keeping a supply of the suspensions of calomel or of salicylate of mercury, it is advisable to prepare a larger quantity of the suspension at once. Pollitzer places the contents of ten ampoules of salvarsan into a sterile mortar and thoroughly triturates the powder with a small portion of 15 c.c. of iodipin (10 per cent.), which has been measured out, reserving some of the iodipin to enable him to work the thick oily mass into a sterile dark glass, glass stoppered bottle. Mortar, pestle, and oil should be warm.

Ten ampoules of salvarsan contain a little more than 6 grm. of the drug. This quantity in 15 c.c. of iodipin makes approximately a 40 per cent. suspension, and 1 c.c. contains, therefore, about 0·4 grm. of salvarsan. It is desirable to have this high percentage, as thereby we are enabled to inject a sufficient dose of the drug in a relatively small volume of oil—an important matter from the point of view of pain to the patient. In general, it may be stated that the larger the volume of the injected mass the greater the damage to the tissues and the greater the pain. The suspension so prepared is sterile, the iodine of the iodipin keeps it sterile, and there is no reaction between the salvarsan and the iodine which might deleteriously affect the salvarsan. It might be kept indefinitely.

The immediate pain attending the little operation is insignificant; it is not greater than that of an injection of salicylate of mercury. If, however, the injected fluid has been badly placed—not in the body of the muscle—or if some of it has escaped into the connective tissue, there is considerable pain and induration.

The therapeutic effects of these injections are fully equal to those of the subcutaneous or intra-muscular injections of the drug. Whether they equal those following the intra-venous injections we do not yet know; one can make these comparisons only after hundreds of cases have been observed. No doubt the intra-venous is the most comfortable method for the patient, and it is also probably the most efficient. The theoretical assumption that the absorption and therefore the action of the drug is slow in the oil method is not justified by experience.

J. L. B.

THE SPIROCHÆTE PALLIDA OF SCHAUDINN AND THE DIAGNOSIS OF SYPHILIS. Thibierge, Ravaut and Le Sourd. (*Bull. et Mém. de la Soc. Méd des Hôp. de Paris*, April 6th.)

At the present moment the diagnosis of difficult syphilitic cases depends so much upon the Wassermann reaction that microscopic research of the spirochæte has somewhat lost its importance. But this paper is of interest inasmuch as it deals with the possibilities and difficulties of detecting the presence of the organism in cases where the Wassermann reaction is either positive or negative.

and which are still syphilitic. Of 52 patients with syphilitic lesions examined, 19 had chancres, 20 had secondary lesions, and in 13 cases the fluid drawn off from syphilitic inguinal glands was investigated. In the first group the spirochæte was found in 17 cases; in the second group it was found in 8 out of 11 cases of mucous patches, in 7 out of 9 other secondary cases it was demonstrated; in the last group, however, the organism was only found in 3 out of 13 cases.

When the spirochæte cannot be demonstrated in scrapings from a syphilitic lesion, the authors recommend that it should be sought in sections, and if the result is still negative a monkey should be inoculated. The results obtained with the *Macacus* monkey have been satisfactory, and, of course, the cost of such animals is very much less than that of chimpanzees. It is of interest to notice that the inoculation of the virus from the first monkey to a second and even a third generation has been possible, and that, even in the last, numerous spirochætes have been found. But the initial expense, and the difficulties of housing and keeping even *Macacus* monkeys, must make this method difficult of acceptance as a routine method for the diagnosis of syphilis, and it is probable that in this country at least it will not displace the generally accepted Wassermann reaction.

J. L. B.

LUMBAR PUNCTURE IN PRURIGINOUS DERMATOSES. THIBIERGE. (*Comptes-rendus du Xme Congrès français de Médecine.*)

WHEN I was working in Paris some years ago I had an opportunity of seeing in Dr. Thibierge's clinic some of these lumbar punctures in Lichen planus and other forms of pruritus undertaken by Dr. Ravaut. And, although the fluid thus obtained from cases of urticaria, Dermatitis herpetiformis, etc., showed no lymphocytosis, and therefore was of no assistance from the point of view of diagnosis, it is remarkable how the puncture, either by diminution of intra-rhachidian pressure or by other means, diminishes the pruritus and even cures or favourably influences the progress of early cases of the lichen of Wilson and the Lichen simplex chronicus of Vidal. The final conclusions of Thibierge on this subject are included in this paper, and will repay perusal by all who are interested in the relation of lumbar puncture to skin-diseases.

J. L. B.

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